SERFF Tracking Number:	*HUMA-126873314*	*State:*	*Arkansas*
Filing Company:	*Humana Insurance Company*	*State Tracking Number:*	*47235*
Company Tracking Number:			
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*HumanaOne Individual Application(Life)*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Humana Insurance Company

Product Name: HumanaOne Individual Application(Life)	SERFF Tr Num: HUMA-126873314	State: Arkansas
TOI: L04I Individual Life - Term	SERFF Status: Closed-Approved-Closed	State Tr Num: 47235
Sub-TOI: L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Author: Latunia Riley	Disposition Date: 11/09/2010
	Date Submitted: 11/08/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:
State Filing Description:		

General Information

Project Name:	Status of Filing in Domicile:
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 11/09/2010	Explanation for Other Group Market Type:
	State Status Changed: 11/09/2010
Deemer Date:	Created By: Latunia Riley
Submitted By: Latunia Riley	Corresponding Filing Tracking Number: AR-10-011-H1

Filing Description:
New Life Insurance Application Filing

Company and Contact

Filing Contact Information

SERFF Tracking Number:	*HUMA-126873314*	*State:*	*Arkansas*
Filing Company:	*Humana Insurance Company*	*State Tracking Number:*	*47235*
Company Tracking Number:			
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*HumanaOne Individual Application(Life)*		
Project Name/Number:	*/*		

Latunia Riley, Contract Analyst
2 Riverwood Place
W24133 Riverwood Dr.
Suite 250
Waukesha, WI 53188

lriley2@humana.com
262-951-2617 [Phone]

Filing Company Information

Humana Insurance Company	CoCode: 73288	State of Domicile: Wisconsin
1100 Employers Boulevard	Group Code: 119	Company Type: Life & Health
Green Bay, WI 54344	Group Name:	State ID Number:
(800) 558-4444 ext. [Phone]	FEIN Number: 39-1263473	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Humana Insurance Company	$50.00	11/08/2010	41626507

SERFF Tracking Number:	*HUMA-126873314*	*State:*	*Arkansas*
Filing Company:	*Humana Insurance Company*	*State Tracking Number:*	*47235*
Company Tracking Number:			
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*HumanaOne Individual Application(Life)*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	11/09/2010	11/09/2010

SERFF Tracking Number:	*HUMA-126873314*	*State:*	*Arkansas*
Filing Company:	*Humana Insurance Company*	*State Tracking Number:*	*47235*
Company Tracking Number:			
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*HumanaOne Individual Application(Life)*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 11/09/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*HUMA-126873314*	*State:*	*Arkansas*
Filing Company:	*Humana Insurance Company*	*State Tracking Number:*	*47235*
Company Tracking Number:			
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*HumanaOne Individual Application(Life)*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Cover Letter		Yes
Supporting Document	Transmittal Document		Yes
Supporting Document	Statement of Variability		Yes
Form	HumanaOne Individual Application(Life)		Yes

SERFF Tracking Number:	*HUMA-126873314*	*State:*	*Arkansas*
Filing Company:	*Humana Insurance Company*	*State Tracking Number:*	*47235*
Company Tracking Number:			
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*HumanaOne Individual Application(Life)*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: AR-71002 8/2010

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	AR-71002 8/2010	Application/ Enrollment Form	HumanaOne Individual Application(Life)	Initial		42.700	AR-71002-0810.pdf

HumanaOne Individual Insurance Application

HUMANA One

[Arkansas]

Please print clearly in ink. Complete all questions. Fill in all fields or indicate "not applicable."

Date of application: __ __/__ __/__ __ __ __ **Requested Effective Date:** __ __/__ __/__ __ __ __

This application is for: ❑ New Business (First time applicant) ❑ Reinstatement (Reapplication)
❑ Change/Modification to Existing Policy

Reason for change _____ Change/Modification to Existing Policy # _____

Coverage Options

[Health Coverage

Please complete this section when selecting a health plan.

Plan name

Deductible $]

[Dental Coverage

❑ [Plan name] ❑ [Plan name]
❑ [Plan name] ❑ [Plan name]
❑ [Plan name] ❑ [Plan name]]

[Vision Coverage

❑ [Plan name]
❑ [Plan name]
❑ [Plan name]]

[Optional Benefits

Please select an optional benefit if available with chosen health plan.

[❑ Office visit copay]

[❑ Prescription drug deductible: ❑[$0-2,000] ❑[$0-2,000] ❑[$0-2,000]]

[❑ Supplemental Accident Benefit: ❑[$100-5,000] ❑[$100-5,000] ❑[$100-5,000]]

[❑ Mental Disorder Benefit]

[❑ Carryover Deductible]]

[Your billing and effective date for the vision product will be determined once your medical plan is issued. The effective date can be up to [0-45] days after the medical plan is issued. The initial payment will be taken at the time the vision policy is issued; subsequent payment will be billed on the [15th] of each month.]

[Please note: You may purchase [dental] [or vision] coverage if health coverage is chosen. [If [dental] [or vision] is selected, it will be approved if the health coverage is approved.] [If you are changing or modifying an existing/approved policy or plan, [dental] [or vision] is only available at your anniversary.]]

[Life Coverage

Please complete this section if choosing the term life rider or the term life plan for primary applicant and/or spouse.
Please include an additional page if you need to list multiple beneficiaries. Each additional page must be signed and dated.

Primary Applicant:

[❑ [$0-20,000] Term Life Rider (can only be purchased with a health plan)

Primary beneficiary name

Relationship Benefit %

Contingent beneficiary name

Relationship Benefit %]

[❑ Term Life Plan (Minimum selection is [$0-1,000,000]. Maximum selection is [$0-1,000,000]. Amounts must be purchased in [$0-100,000] increments.)

Term life insurance amount: $_____

Term length: ❑ [0-50] years ❑ [0-50] years ❑ [0-50] years

Primary beneficiary name

Relationship Benefit %

Contingent beneficiary name

Relationship Benefit %]

Spouse:

[❑ [$0-20,000] Term Life Rider (can only be purchased with a health plan)

Primary beneficiary name

Relationship Benefit %

Contingent beneficiary name

Relationship Benefit %]

[❑ Term Life Plan (Minimum selection is [$0-1,000,000]. Maximum selection is [$0-1,000,000]. Amounts must be purchased in [$0-100,000] increments.)

Term life insurance amount: $_____

Term length: ❑ [0-50] years ❑ [0-50] years ❑ [0-50] years

Primary beneficiary name

Relationship Benefit %

Contingent beneficiary name

Relationship Benefit %]]

Primary Applicant Information

[If child-only coverage is requested, the youngest child is the Primary Applicant. Questions must be filled out by custodial parent or legal guardian.]

First name	MI	Last name	Height	Weight	Gender ❑ M ❑ F	Date of birth / /
Home address (not P.O. Box)			City		State	ZIP code
Social Security #		Country or State of birth		E-mail		
Type of business or industry		Occupation	Home phone # ( )		Daytime phone # ( )	
Mailing address (if different from home address)			City		State	ZIP code
[Policyholder name if different than Primary Applicant (applicable for child-only application)]						

Parent or Guardian Information

Please complete this section if Primary Applicant is under [0-40] years of age.

First name	MI	Last name	E-mail	
Home address (not P.O. Box)		City	State	ZIP code
Home phone # ( )		Daytime phone # ( )	Relationship to child(ren)	

Family Information

Please complete only if your spouse and/or dependent children are applying for coverage. Attach an additional family information sheet if necessary. Each additional page must be signed and dated.

Spouse First name	MI	Last name	Height	Weight	Gender ❑ M ❑ F	Date of birth / /
Country or State of birth	Spouse's type of business or industry		Spouse's occupation			
Social Security #		E-mail				

Dependent 1 First name	MI	Last name	Height	Weight	Gender ❑ M ❑ F	Date of birth / /
[Full-time student (if [0-40] or older) ❑ No ❑ Yes]	[Married ❑ No ❑ Yes]	[Residential address different than primary applicant? ❑ No ❑ Yes]				

Dependent 2 First name	MI	Last name	Height	Weight	Gender ❑ M ❑ F	Date of birth / /
[Full-time student (if [0-40] or older) ❑ No ❑ Yes]	[Married ❑ No ❑ Yes]	[Residential address different than primary applicant? ❑ No ❑ Yes]				

Dependent 3 First name	MI	Last name	Height	Weight	Gender ❑ M ❑ F	Date of birth / /
[Full-time student (if [0-40] or older) ❑ No ❑ Yes]	[Married ❑ No ❑ Yes]	[Residential address different than primary applicant? ❑ No ❑ Yes]				

Dependent 4 First name	MI	Last name	Height	Weight	Gender ❑ M ❑ F	Date of birth / /
[Full-time student (if [0-40] or older) ❑ No ❑ Yes]	[Married ❑ No ❑ Yes]	[Residential address different than primary applicant? ❑ No ❑ Yes]				

Existing/Prior Coverage

IMPORTANT: DO NOT cancel any existing coverage until you receive written notification from Humana of your acceptance for coverage.

• Existing or Prior Health Coverage

If you are applying for health coverage, please provide the status of current coverage or coverage within the past [1-24] months, including Humana, for each applicant. If additional space is needed, please attach additional pages. Each additional page must be signed and dated.

[❑ No ❑ Yes Do you or anyone applying for coverage have any major medical health insurance coverage currently in force?]

[• ***If YES, please supply the following for all applicants applying for coverage on the policy:***

Name(s) of covered persons

Major Medical Insurance Carrier Name Effective Date __ __ / __ __ / __ __ __ __]

[• ***If NO, please answer the following question:***

❑ No ❑ Yes Have you or anyone applying for coverage had major medical health insurance coverage within the past [1-24] months?]

[• ***If YES, please supply the following for all applicants applying for coverage on the policy:***

Name(s) of covered persons

Major Medical Insurance Carrier Name

Effective Date __ __ / __ __ / __ __ __ __

Termination Date __ __ / __ __ / __ __ __ __]

• Existing Dental Coverage

[1. ❑ No ❑ Yes Does anyone applying for coverage currently have or had any group or individual dental coverage within the last [1-24] months?]

[• ***If YES, please supply the following for all applicants applying for coverage on the policy:***

Name(s) Effective Date __ __ / __ __ / __ __ __ __

Insurance Carrier Name Termination Date __ __ / __ __ / __ __ __ __

Name(s) Effective Date __ __ / __ __ / __ __ __ __

Insurance Carrier Name Termination Date __ __ / __ __ / __ __ __ __]

[2. ❑ No ❑ Yes Will the insurance coverage applied for be used to replace existing dental coverage?]

• Existing Life Coverage

Primary Applicant:

[1. ❑ No ❑ Yes Do you have any life insurance and/or annuity coverage currently in force?]

[2. ❑ No ❑ Yes Will the insurance coverage applied for be used to replace any existing life and/or annuity coverage?]

[• ***If YES, please supply the following information:***

Company name Amount $ Policy #]

Spouse:

[1. ❑ No ❑ Yes Do you have any life insurance and/or annuity coverage currently in force?]

[2. ❑ No ❑ Yes Will the insurance coverage applied for be used to replace any existing life and/or annuity coverage?]

[• ***If YES, please supply the following information:***

Company name Amount $ Policy #]

Eligibility & Health Status

Please answer for all individuals applying for coverage.

[Quoted premiums are only an estimate. We may need to adjust your premium based on underwriting. If the difference is [1-20] percent or less, we'll adjust your premium automatically. If the difference is more than [1-20] percent, we'll contact you.]

For this insurance to be issued, the following eligibility and health questions must be answered fully and truthfully. All requested health information including routine physical exams and information related to spouse and dependents applying for coverage must be provided. If any of the answers are "yes", please provide complete details. Failure to [fully] disclose any eligibility or health information may cause your claim to be reduced or denied, [including the applicability of a condition specific deductible;] or may result in your policy being rescinded or modified back to your original effective date.

[1. ❑ No ❑ Yes Is anyone applying for coverage a citizen of a country other than the United States?]

[• ***If YES:*** Name(s):]

[Has anyone applying for coverage:]

[2. ❑ No ❑ Yes Experienced weight gain or loss of more than [0-100] pounds in the past [1-24] months?]

[3. Within the past [1-24] months, has the primary applicant, or spouse or dependent applying for coverage used any tobacco product?]

[Primary Applicant: ❑ No ❑ Yes] **[Spouse:** ❑ No ❑ Yes] **[Dependent:** ❑ No ❑ Yes]

[4. ❑ No ❑ Yes Has anyone applying for coverage participated in any dangerous or extreme sport activity in the past [1-24] months or plan to participate in the future?]

[5. ❑ No ❑ Yes Are you or is any immediate family member (whether applying for coverage or not) pregnant, an expectant parent, in the process of adopting a child, or undergoing infertility treatment?]

[Within the past [1-5] years, has anyone applying for coverage:]

[6. ❑ No ❑ Yes Been denied for health or life insurance or had their health coverage [ridered,] [rated] or [rescinded]?]

[7. ❑ No ❑ Yes Been diagnosed with or received treatment for AIDS, or tested positive for AIDS or HIV?]

[8. ❑ No ❑ Yes Had any signs or symptoms of, been diagnosed with, sought counsel for or treated for any alcohol abuse, dependency or problem, or had any alcohol related arrests?]

[9. ❑ No ❑ Yes Used any illegal or taken prescription drugs not prescribed by their health care provider or had any signs or symptoms of, been diagnosed with, sought counsel for or treated for any drug abuse, dependency or problem; or had any drug related arrests?]

[10. ❑ No ❑ Yes Had any testing or procedure performed that has been abnormal or the results of which are pending or unknown?]

[11. ❑ No ❑ Yes Had surgery or been advised to have surgery that has not been completed?]

[12. ❑ No ❑ Yes Consulted, advised or recommended to have follow-up testing or treatment by a health care provider or specialist that has not been completed?]

Eligibility & Health Status continued

[13. **Within the past [1-5] years,** has anyone applying for coverage had signs of, been prescribed medication or received injections for, or been diagnosed with or treated for:

[A. ❑ No ❑ Yes	Chest pain or Heart Attack]	[M. ❑ No ❑ Yes	ADD/ADHD (Attention Deficit Disorder) or any other Behavioral, Emotional, Mental or Nervous Disorders]
[B. ❑ No ❑ Yes	High Blood Pressure or Hypertension]	[N. ❑ No ❑ Yes	Eating Disorder]
[C. ❑ No ❑ Yes	High Cholesterol or Triglycerides]	[O. ❑ No ❑ Yes	Developmental Disorder or Delay]
[D. ❑ No ❑ Yes	Cancer or Tumor of any kind]	[P. ❑ No ❑ Yes	Human Papilloma Virus or Sexually Transmitted Disease]
[E. ❑ No ❑ Yes	Diabetes or High Blood Sugar]	[Q. ❑ No ❑ Yes	Infertility]
[F. ❑ No ❑ Yes	Stroke]	[R. ❑ No ❑ Yes	Uterine Fibroids]
[G. ❑ No ❑ Yes	Paralysis]	[S. ❑ No ❑ Yes	Cyst, Growth, Lump or Polyp]
[H. ❑ No ❑ Yes	Epilepsy or Seizure]	[T. ❑ No ❑ Yes	Hernia]
[I. ❑ No ❑ Yes	Migraines or frequent or severe headaches]	[U. ❑ No ❑ Yes	Arthritis]
[J. ❑ No ❑ Yes	Hepatitis]	[V. ❑ No ❑ Yes	Implants, Pins, Plates, Rods, Screws or Prosthesis]
[K. ❑ No ❑ Yes	Sleep Apnea]	[W. ❑ No ❑ Yes	Connective Tissue or Autoimmune Disorder]
[L. ❑ No ❑ Yes	Anxiety or Depression]	[X. ❑ No ❑ Yes	Birth Defect]]

[14. **Within the past [1-5] years,** has anyone applying for coverage been prescribed medication or received injections for, been treated for or had signs or symptoms of any injury, condition, disease or disorder involving or affecting:

[A. ❑ No ❑ Yes	Gallbladder, Liver or Pancreas]	[G. ❑ No ❑ Yes	Eyes, Ears, Nose, Throat or Sinuses]
[B. ❑ No ❑ Yes	Colon, Esophagus or Stomach]	[H. ❑ No ❑ Yes	Breasts]
[C. ❑ No ❑ Yes	Bladder or Kidneys]	[I. ❑ No ❑ Yes	Menstrual Cycle]
[D. ❑ No ❑ Yes	Back, Disc, Neck or Spine]	[J. ❑ No ❑ Yes	Cervix, Ovaries, Uterus or Vagina]
[E. ❑ No ❑ Yes	Knee, Hip or Shoulder]	[K. ❑ No ❑ Yes	Penis, Prostate or Testicles]
[F. ❑ No ❑ Yes	Lungs]	[L. ❑ No ❑ Yes	Skin]]

[15. **Within the past [1-5] years,** has anyone applying for coverage been prescribed medication or received injections for, been treated for or had signs or symptoms of any injury, condition, disease or disorder (not previously disclosed) involving or affecting:

[A. ❑ No ❑ Yes	Blood Vessels, Heart or Circulatory System]	[E. ❑ No ❑ Yes	Urinary System]
[B. ❑ No ❑ Yes	Blood, Gland, Pituitary, Thyroid or Lymph System]	[F. ❑ No ❑ Yes	Musculoskeletal System, including Bone/Joint Disorders]
[C. ❑ No ❑ Yes	Brain or Nervous System]	[G. ❑ No ❑ Yes	Respiratory System]
[D. ❑ No ❑ Yes	Digestive System]	[H. ❑ No ❑ Yes	Reproductive System]]

[16. ❑ No ❑ Yes Within the past [1-24] [months] [1-5] [years], has anyone applying for coverage seen a health care provider or specialist for a routine physical/wellness exam, or been seen for *any* reason not previously disclosed?]

[17. ❑ No ❑ Yes Within the past [1-24] months, has anyone applying for coverage been advised to take or taken any prescription medications or injections not previously disclosed?]]

[Additional Eligibility or Health Status Question Information

To be completed if anyone applying for coverage answered "Yes" to any question(s) in the Eligibility & Health Status section. Please provide details such as; specific condition, dates of treatment, results or advice given, medication (dosage and frequency), treatment plan, recovery date, physician name and address. Attach an additional health information sheet if necessary. Additional information sheets must be signed and dated by the primary applicant or legal representative and/or spouse (if applying).

[Question #	Letter	Person treated	Condition
Details:			]

[Question #	Letter	Person treated	Condition
Details:			]

[Question #	Letter	Person treated	Condition
Details:			]]

Agreement and Signature

True and Complete Acknowledgment: I understand, agree and represent: I have read this document or it has been read to me. The answers are true and complete. I agree to immediately notify Humana of any changes to the information contained in this form that occur prior to the policy effective date. [I have received and reviewed any state or federal required disclosures.] I acknowledge that neither I nor the agent have the right to waive or incompletely answer any question, determine coverage or insurability, alter any contract, or waive any of Humana's other rights and requirements. This policy applied for is not an employer-sponsored group health plan and it does not comply with state or federal small employer laws. I certify that I will not use pre-tax income to pay premiums associated with this policy or otherwise receive favorable tax treatment under federal or state law that will be used to pay insurance premiums. If this application for coverage is accepted, coverage will be effective on the date specified by Humana on the policy. [Unless Humana agrees to an earlier date, the effective date for sickness begins on the 15th day after the approved effective date of the policy.] Acceptance of premium and fees does not guarantee coverage. Any misrepresentation on this application may be used by Humana during the first [0-2] policy years to void the contract or modify the terms of coverage. This may result in loss of coverage, modification of coverage and/or claim denial. I agree to terminate any existing coverage if this application is approved and coverage accepted. [As a parent or legal guardian of a dependent [under the age of] [0-40] years [or older] applying for coverage, I attest by my signature below, that I have gathered the necessary health information regarding my dependent in order to fully and truthfully complete this application.] [A minimum [0-2] year contract is required for vision plans offered by Humana Insurance Company.]

This document, together with any supplements, will form part of and be the basis for any policy issued.

Any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

If you decide not to sign this agreement, we will be unable to enroll you in a Humana*One* medical plan.

➲ Primary Applicant or Legal Guardian Signature _____ Date __ __/__ __/__ __ __ __

➲ Relationship of Legal Guardian_____

➲ Spouse Signature (if covered dependent) _____ Date __ __/__ __/__ __ __ __

(if covered dependent)

[➲ Dependent Signature [(if over [0-40])] [(if [0-40] and older)] [(if you are between the ages of [0-40] and [0-40])]____ Date __ __/__ __/__ __ __ __]

[➲ Dependent Signature [(if over [0-40])] [(if [0-40] and older)] [(if you are between the ages of [0-40] and [0-40])]____ Date __ __/__ __/__ __ __ __]

Agent / Producer Information

This section to be completed by Agent or Producer.

[1. Agent / Agency of Record: [(for commissions and correspondence)]	**[2. Agent / Agency of Record: [(for split-commissions)]**
Name (print)	Name (print)
Humana Agent #	Humana Agent #
[Commission split: ❑ No ❑ Yes	[Percentage of sales: ❑ No ❑ Yes
If yes, percentage (Total should equal 100%)]]	If yes, percentage (Total should equal 100%)]]

[**1. Writing Agent / Producer:**	**[2. Writing Agent / Producer: (for split-commissions)**
Name (print)	Name (print)
Humana Agent #	Humana Agent #
Arkansas license #	Arkansas license #
Signature	Signature
[Commission split: ❑ No ❑ Yes	[Percentage of sales: ❑ No ❑ Yes
If yes, percentage (Total should equal 100%)]]	If yes, percentage (Total should equal 100%)]]

Agent replacement question:

[Will this policy replace or change any existing life insurance policy(s) and/or annuity(s)? ❑ No ❑ Yes]

As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the primary applicant submitting this application in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the primary applicant in the benefit summary document or other plan literature.

Writing Agent's Signature_____ Date __ __/__ __/__ __ __ __]

[The original version of this Agreement is in the English language. If there are any discrepancies or conflicts between the English and any other version that has been translated into another language, the English version will control.]

The offering Company(ies) listed below, severally or collectively, as the content may require, are referred to in this application as "Humana."

[[Medical] and [Life] products insured by Humana Insurance Company]
[Dental products insured by HumanaDental Insurance Company]
[Dental product [insured] or [administered] by American Dental Providers of Arkansas, Inc.]
[Vision products [insured] or [administered] by Humana Insurance Company]

HUMANA®
Guidance when you need it most

PDN: _____
(FOR INTERNAL USE ONLY)

SERFF Tracking Number:	*HUMA-126873314*	*State:*	*Arkansas*
Filing Company:	*Humana Insurance Company*	*State Tracking Number:*	*47235*
Company Tracking Number:			
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*HumanaOne Individual Application(Life)*		
Project Name/Number:	*/*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification
Comments:
Attachment:
Certificate of Readability.pdf

Item Status: **Status Date:**

Satisfied - Item: Cover Letter
Comments:
Attachment:
Filing Cover Letter.App-Enroll Only.pdf

Item Status: **Status Date:**

Satisfied - Item: Transmittal Document
Comments:
Attachment:
Arkansas NAIC Transmittal Document.pdf

Item Status: **Status Date:**

Satisfied - Item: Statement of Variability
Comments:
Attachment:
Generic SOV.Application-Enrollment 7-2010.pdf

HUMANA INSURANCE COMPANY

CERTIFICATION

RE: AR-71002 8/2010

I hereby certify, to the best of my knowledge and belief, that the enclosed form(s) comply(ies) with the requirements of Arkansas Insurance Code 23-80-206.

Form Number(s)	**Flesch Test Reading Ease Score**
AR-71002 8/2010	42.7

Signed by: _____

Steve DeRaleau
Vice President

Date: November 8, 2010

HUMANA.
Guidance when you need it most

November 8, 2010

Life and Health Division
Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201

RE: Humana Insurance Company
Individual Life Form Filing
Application: AR-71002 8/2010
NAIC #73288
FEIN # 39-1263473

Dear Sir/Madam:

We are enclosing the above-referenced form for your review and approval. This form is new and will not replace any previously filed or approved form. The Application is being filed for general use with all approved policy series.

The Application may be offered in a printed, online, or digitized audio recorded format.

Included with this submission are:
- Readability Certification;
- NAIC Transmittal Document; and
- Statement of Variability.

If you have any questions regarding this filing, please contact me by phone at 1-800-289-0260, extension 2617, by fax at 920-632-0029 or by e-mail at lriley2@humana.com.

Sincerely,
Humana Insurance Company
Latunia Riley

Latunia Riley
Contract Analyst

Effective January 1, 2009

Reset Form

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	Arkansas

2.	Department Use Only
	State Tracking ID

3.	Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
	Humana Insurance Company N19 W24133 Riverwood Drive Ste 250 Waukesha, WI 53188	Wisconsin	Life, Accident & Health	119	73288	391263473	

4.	Contact Name & Address	Telephone #	Fax #	E-mail Address
	Latunia Riley (Contract Analyst) Humana Insurance Company N19 W24133 Riverwood Drive Waukesha, WI 53188	800-289-0260 ext 2617	920-632-0029	lriley2@humana.com

5.	Requested Filing Mode	☑ Review & Approval ☐ File & Use ☐ Informational ☐ Combination (please explain): _____ ☐ Other (please explain): _____

6.	Company Tracking Number	AR-10-011-H1	
7.	☑ **New Submission** ☐ **Resubmission**	Previous file # _____	
8.	**Market**	☑ Individual ☐ Franchise	
		Group	☐ Small ☐ Large ☐ Small and Large ☐ Employer ☐ Association ☐ Blanket ☐ Discretionary ☐ Trust ☐ Other: _____
9.	**Type of Insurance**	**L04I Individual Life-Term**	
10.	**Product Coding Matrix Filing Code**	**L04I.203 Specified Age or Duration - Single Premium - Single Life**	
11.	**Submitted Documents**	☑ **FORMS** ☐ Policy ☐ Outline of Coverage ☐ Certificate ☑ Application/Enrollment ☐ Rider/Endorsement ☐ Advertising ☐ Schedule of Benefits ☐ Other **Rates** ☐ New Rate ☐ Revised Rate ☐ **FILING OTHER THAN FORM OR RATE:** Please explain: _____ **SUPPORTING DOCUMENTATION** ☐ Articles of Incorporation ☐ Third Party Authorization ☐ Association Bylaws ☐ Trust Agreements ☑ Statement of Variability ☑ Certifications ☐ Actuarial Memorandum ☐ Other_____	

12.	**Filing Submission Date**	11/08/2010
13	**Filing Fee (If required)**	Amount $50.00 Check Date EFT Retaliatory ☐ Yes ☑ No Check Number
14.	**Date of Domiciliary Approval**	Forms unique to Arkansas

15. Filing Description:

See Cover Letter

View Complete Filing Description

16. Certification (If required)

I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of Arkansas.

Print Name Latunia Riley Title Contract Analyst

Signature Latunia Riley Digitally signed by Latunia Riley DN: cn=Latunia Riley, o, ou, email=lriley2@humana.com, c=US Date: 2010.11.08 08:13:39 -06'00' Date: 11/8/2010

17.	Form Filing Attachment
This filing transmittal is part of company tracking number	AR-10-011-H1
This filing corresponds to rate filing company tracking number	N/A

	Document Name / Description	Form Number		Replaced Form Number / Previous State Filing Number
01	Humana One Individual Insurance Application Application	AR-71002 8//2010	☐ Initial ☑ Revised ☐ Other _____	N/A
02			☐ Initial ☐ Revised ☐ Other _____	
03			☐ Initial ☐ Revised ☐ Other _____	
04			☐ Initial ☐ Revised ☐ Other _____	
05			☐ Initial ☐ Revised ☐ Other _____	
06			☐ Initial ☐ Revised ☐ Other _____	
07			☐ Initial ☐ Revised ☐ Other _____	
08			☐ Initial ☐ Revised ☐ Other _____	
09			☐ Initial ☐ Revised ☐ Other _____	
10			☐ Initial ☐ Revised ☐ Other _____	

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18.	Rate Filing Attachment			
This filing transmittal is part of company tracking number				
This filing corresponds to form filing company tracking number			AR-10-011-H1	
Overall percentage rate indication (when applicable)			N/A	
Overall percentage rate impact for this filing			N/A %	
	Document Name **Description**	**Affected Form Numbers**		**Previous State Filing Number**
01			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
02			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
03			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
04			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
05			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
06			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
07			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
08			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
09			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
10			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	

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HUMANA.
Guidance when you need it most

Statement of Variability for Application/Enrollment Forms

Bracketed Sections

1. Bracketed sections will refer to an entire portion of the form such as logos, product offerings, medical or eligibility questions, or agreements.

2. Bracketed sections are identified by green brackets.

   NOTE: Some exceptions will apply due to state requirements or rulings regarding bracketing.

3. Bracketed sections vary to the extent that such sections may be included, omitted or transferred to another page to suit the needs of a particular policyholder subject to any statutory or regulatory requirements.

   - For example: We have filed the Dental section of an application but the applicant did not select Dental then that section will not appear.

4. Bracketed variables such as logos, text, or numbers are subject to change as outlined within the various sections of this document.

Bracketed Numbers

1. With the exception of form numbers and matrix numbers, if allowed by the state, all bracketed numbers are variable.

   - Form numbers are located in the lower left-hand corner of the form and are not subject to change without refilling.

   - Revision numbers are located in the lower right-hand corner of the form and are considered variable and included within this statement.

2. Bracketed numbers within a section are determined by the laws of the governing jurisdiction and will be varied only within the confines of the law.

3. Bracketed numbers will include the minimum and maximum ranges.

Bracketed Questions

1. Text within the bracketed question will not change (Refers to language only. See # 3 for formatting and placement changes).

2. Any bracketed variables within that question are subject to change.

3. Bracketed questions vary only to the extent that such questions may be included, omitted or transferred within the form subject to any statutory or regulatory requirements.

Instructions or Help Text

1. Bracketed instructional text varies to the extent that such text may be included, omitted or transferred to another page to meet the needs of applicants completing the application.

2. Humana reserves the right to make minor instructional or help text revisions, even if it is not bracketed, as needed to clarify instructions for completion of the application and amend the language to clarify the intent within the confines of the law.

Product Information

1. Product information may vary to the extent such information may be included, omitted, or transferred to another page subject to any statutory or regulatory requirements

2. Additional fields within an existing product offering section can be added to an application without refiling for the purpose of offering new insurance products or benefits subject to
    - prior approval of certificate or policy forms for the new products or benefits; and,
    - any statutory or regulatory requirements

Legal Entities

1. New product or benefit plan designs or offerings that create a new or modify an existing legal entity will require filing.

2. Legal entities will be bracketed when multiple entities are listed as insuring or administering entities. The applicable entity(s) will be shown based upon the applicant's selection.

3. If there is only one legal entity listed as insuring or administering then it will not be bracketed

Demographic Information

Demographic information will not be bracketed but will fall under administrative changes which can be amended without refiling.

Administrative Changes and Clerical Errors

Humana reserves the right to amend the attached form(s) for any minor administrative changes or to fix clerical errors that may have unintentionally gone unnoticed prior to submitting for approval and to amend the language to clarify the intent within the confines of the law.

Formatting

Forms are submitted in filing version format and are subject only to minor modification in paper size, stock, ink, border, and adaptation to computer printing. The application may be offered in a printed, on line, or digitized audio recorded format.